

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS256AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2009
NAME OF PROVIDER OR SUPPLIER LADA'S GROUP CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4621 EXPOSITION AVE LAS VEGAS, NV 89102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on April 29, 2009. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons, Category I residents. The census at the time of the survey was zero. Zero resident files were reviewed and two employee files were reviewed. The facility received a grade of A. The following deficiencies were identified:	Y 000		
Y 070 SS=F	449.196(1)(f) Qualifications of Caregiver-8 hours training NAC 449.196 1. A caregiver of a residential facility must: (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. This Regulation is not met as evidenced by: Based on record review on 4/29/09, the facility failed to ensure that 2 of 2 caregivers received eight hours of annual training (Employee #1 and	Y 070		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS256AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2009
NAME OF PROVIDER OR SUPPLIER LADA'S GROUP CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4621 EXPOSITION AVE LAS VEGAS, NV 89102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 070	Continued From page 1 #2). Severity: 2 Scope: 3	Y 070		
Y 103 SS=F	449.200(1)(d) Personnel File - NAC 441A NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This Regulation is not met as evidenced by: Based on record review on 4/29/09, the facility failed to ensure 1 of 2 caregivers complied with NAC 441A.375 regarding tuberculosis testing (Employee #2) for the protection of all residents. Severity: 2 Scope: 3	Y 103		
Y 444 SS=F	449.229(9) Smoke Detectors NAC 449.229 9. Smoke detectors must be maintained in proper operating conditions at all times and must be tested monthly. The results of the tests pursuant to this subsection must be recorded and maintained at the facility. This Regulation is not met as evidenced by: Based on record review on 4/29/09, the facility did not ensure smoke detectors were tested 12 out of the past 12 months (April, May, June, July,	Y 444		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS256AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2009
NAME OF PROVIDER OR SUPPLIER LADA'S GROUP CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4621 EXPOSITION AVE LAS VEGAS, NV 89102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 444	Continued From page 2 August, September, October, November and December of 2008 and January, February and March of 2009). Severity: 2 Scope: 3	Y 444		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.